

Fig. 1



Fig. 2

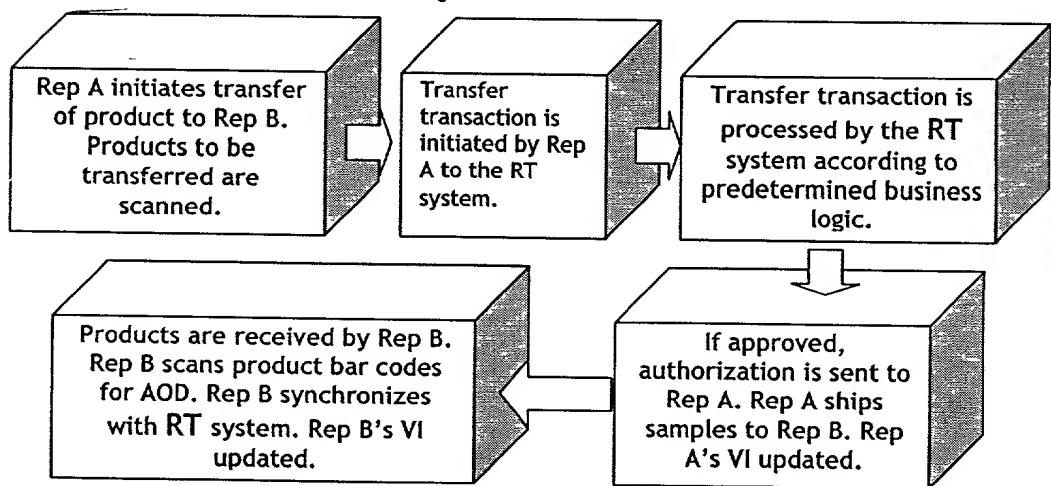


Fig. 3

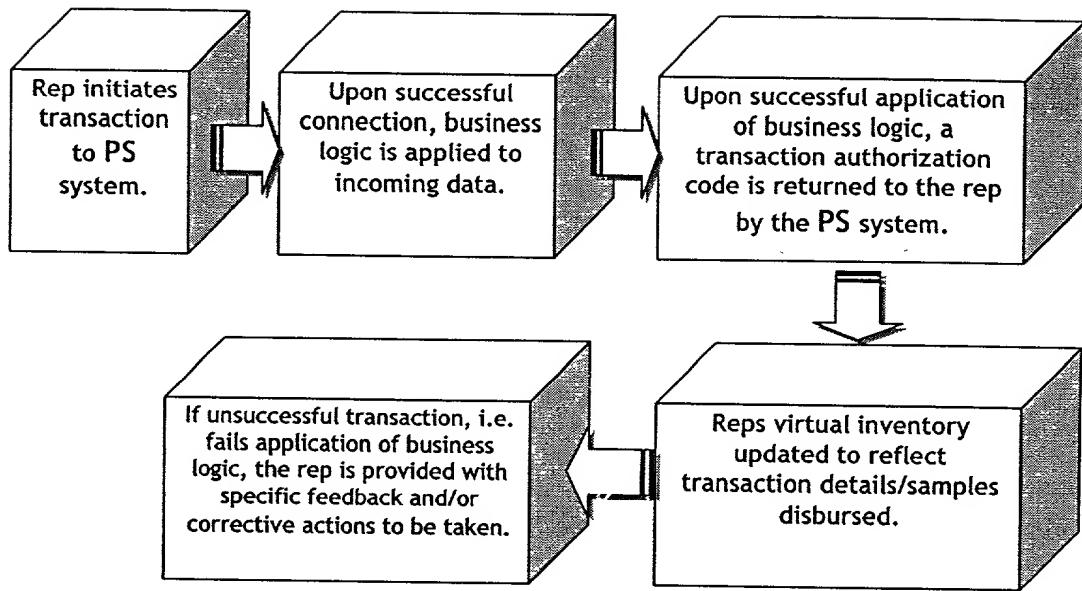


Fig. 4

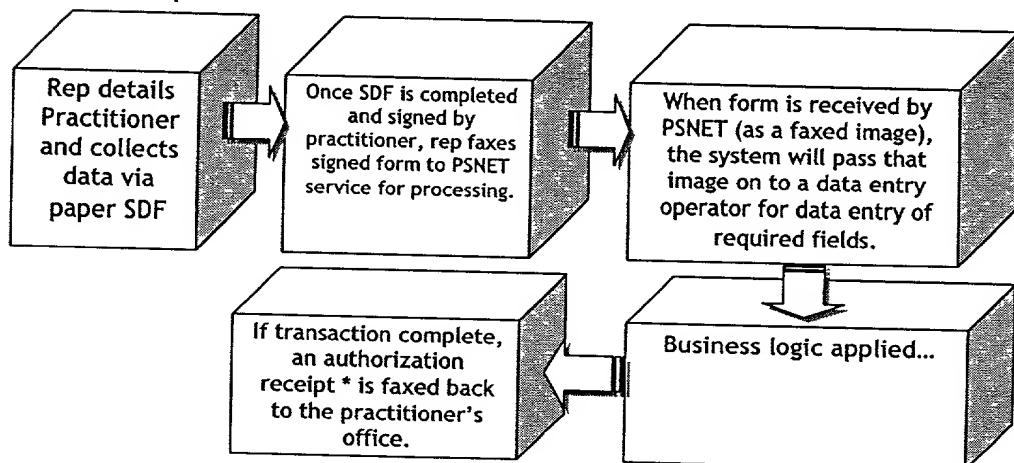


Fig. 5

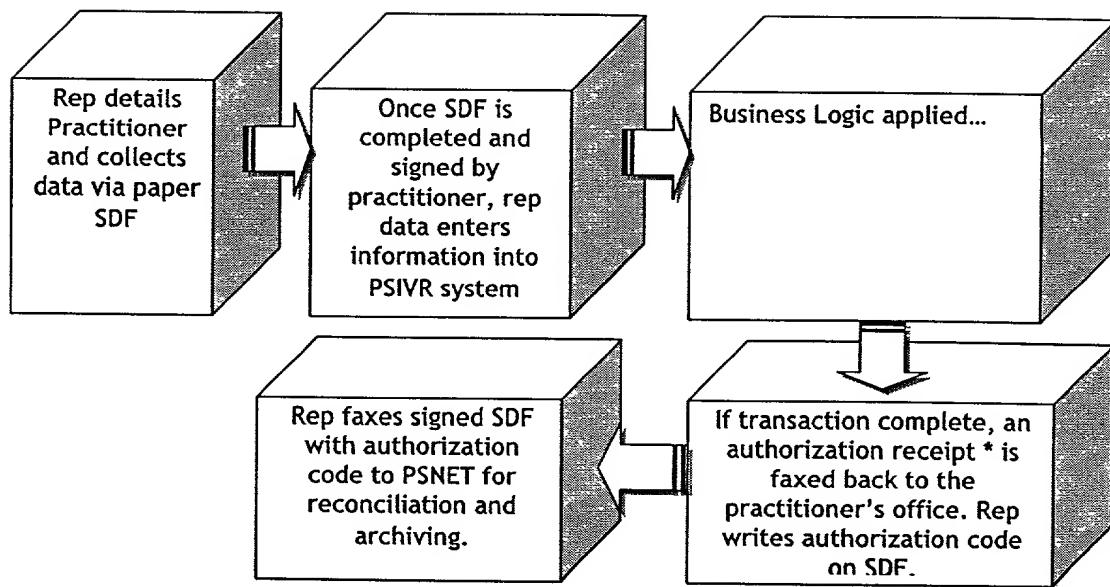


Fig. 6

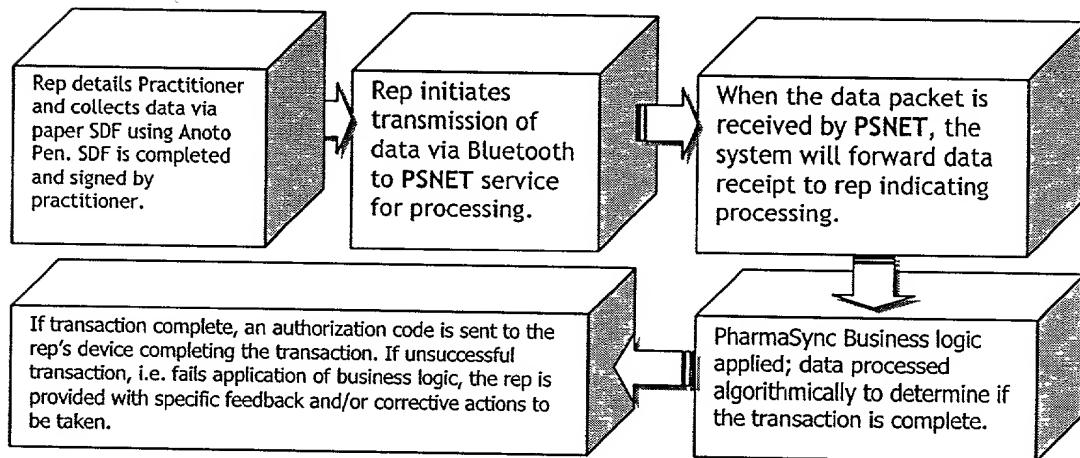


Fig. 7

Pharmaceutics



Rep's Employee #

## Sample Disbursement Form

All information on this form must be completed to be in compliance with federal regulations

Territory Number						

<b>Call Date</b>						

M M D D Y Y Y Y

Rep's Name

	Document Number
	R1234567

Document Number

*Professional designation (please fill in circle)*

MD  DO  PA  NF

Practitioner's Name		
Street Address		
City	State	Zip

**State License #**

I requested and received the samples listed below for the medical needs of my patients, I certify that I am a licensed practitioner in the state shown in my address.

X

**PRACTITIONER'S SIGNATURE & DATE**

Fig. 8

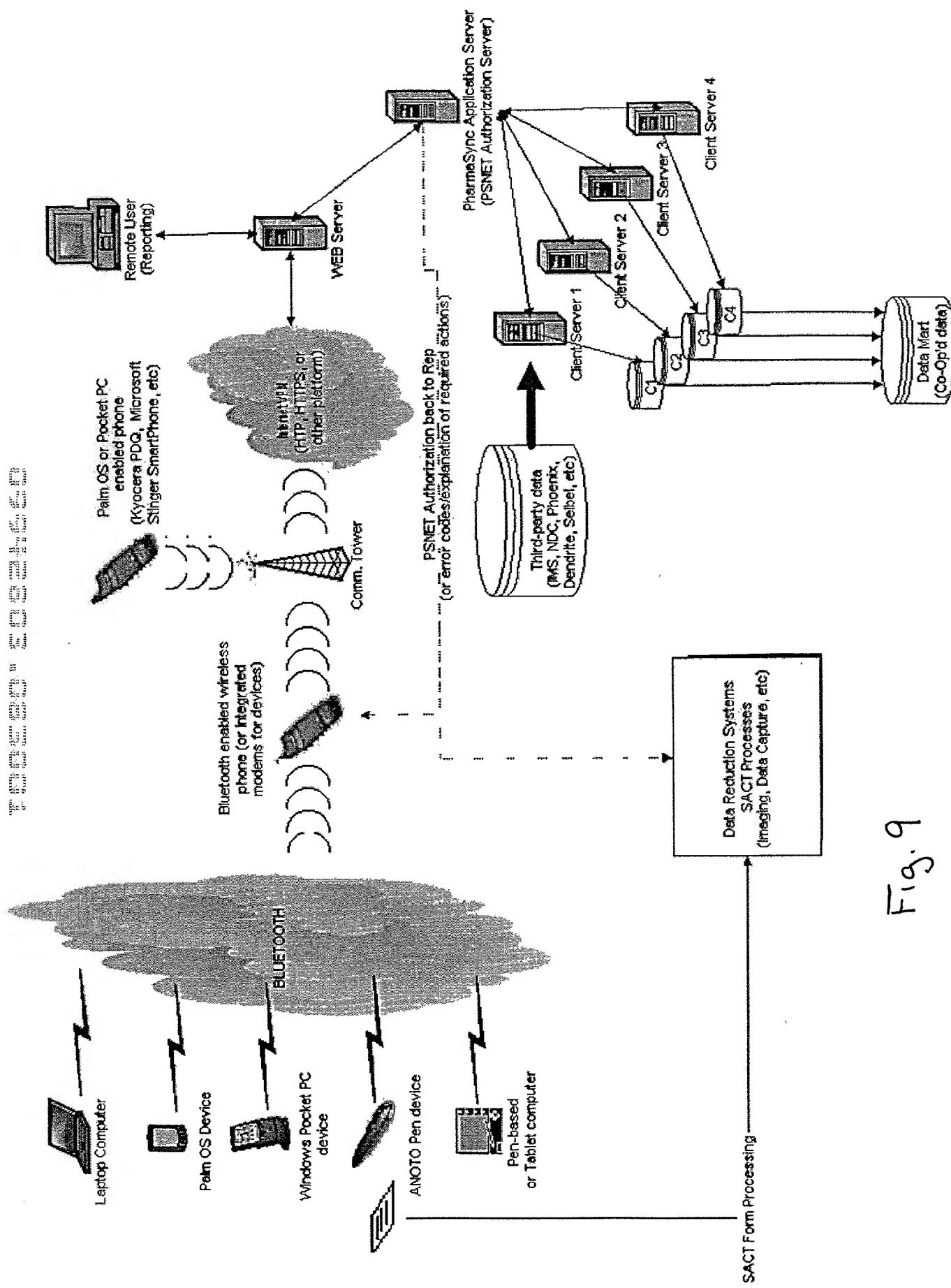


Fig. 9